COUNTY OF ORANGE, CA **HEALTH CARE AGENCY**

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

***NOTE TO CLIENT*: A FEE MAY APPLY TO THIS REQUEST**

YOU HAVE A RIGHT TO RECEIVE A COMPLETED COPY OF THIS FORM
PHOTOCOPY/FACSIMILE COPY MAY BE USED AS AN ORIGINAL

CLIENT(PATIENT) INFORMATION:

[1] NAME: _____
Last *First* *MI*

[2] AKA: _____

[3] SOC. SEC.#: _____ [4] DATE OF BIRTH: _____

I, the undersigned, hereby authorize the [5] ☐ **USE;** [6] ☐ **DISCLOSURE;** [7] ☐ **EXCHANGE;** [8] ☐ **REQUEST** **of the following PHI:**

[9] **PHI From:**	[10] **Disclose PHI To:**
County of Orange Health Care Agency	
9A Name of Facility Producing Records	10A Person/Agency
P.O. Box 355	( ) -
9B Street Address/Mailing Address	10B Street Address 10C Phone Number
Santa Ana, Ca 92702	
9C City, State, Zip	10D City, State, Zip

PHI pertaining to the treatment of psychiatric/mental health/psychotherapy notes; alcohol/substance abuse; HIV/AIDS, sexually transmitted disease (STD) treatment records are covered under the specific confidentiality codes listed for each category below. A general authorization for the disclosure of medical PHI is not sufficient for this purpose. Redisclosure of each of these types of records is prohibited without the specific written authorization of this person to whom the treatment pertains or as otherwise permitted by these regulations or by federal law. The potential for information disclosed pursuant to this authorization is to be subject to disclosure by the recipient and is no longer protected by the County of Orange, Health Care Agency.

PHI TO BE DISCLOSED: (Initial For Each Type of PHI to be disclosed. Please check all that apply)

[11] MEDICAL RECORDS/PHI (California Civil Code 56.10, TITLE 17, Health and Safety Code 120175) AND OTHER INFORMATION

[11A] Initials	[11B] Treatment Date(s):	[11C] Facility Location(s)	[11D] Type of Record(s)/Information to be Released
			☐ Any and All ☐ Specific Record(s)/Info: (Please Indicate Below)

[12] PSYCHIATRIC / MENTAL HEALTH/ PSYCHOTHERAPY NOTES PHI (CAL W&I Code Section 5328)

[12A] Initials	[12B] Treatment Date(s):	[12C] Facility Location(s)	[12D] Type of Record(s)/Information to be Released
			☐ Any and All ☐ Specific Record(s)/Info: (Please Indicate Below) _____

Health and Safety Code 123115 & 123130 - Mental Health Provider: ☐ Approve (Circle one) Copies, Review, Summary or ☐ Deny Access
Signature: _____

[13] ALCOHOL/SUBSTANCE ABUSE TREATMENT PHI (Section 42 Part 2 Code of Federal Regulations)

[13A] Initials	[13B] Treatment Date(s):	[13C] Facility Location(s)	[13D] Type of Record(s)/Information to be Released
			☐ Urine Test Results ☐ Progress in Treatment ☐ Dates of Attendance ☐ Other: _____

[14] HIV RESULTS/AIDS TREATMENT PHI (Health and Safety Code 120980)

[14A] Initials	[14B] Treatment Date(s):	[14C] Facility Location(s)	[14D] Type of Record(s)/Information to be Released
			☐ Any and All ☐ Specific Record(s)/Info: (Please Indicate Below)

[15] **PURPOSE OF THE DISCLOSURE OF PHI:** _____
(e.g., At the request of the Individual, Client (Patient) Review, Continuity of Care, Attorney Access, Court Case, Insurance, Disability, etc.)

[16] **THIS AUTHORIZATION SHALL BECOME VALID IMMEDIATELY AND SHALL REMAIN IN EFFECT FOR THE FOLLOWING PERIOD:**
You may revoke this authorization to disclose PHI in writing at any time. Contact the Custodian of Records office to obtain the form. However, the information may have already been disclosed on the basis of this authorization. (***You must initial one of the following for the authorization to become valid***)

_____ *Initials* [16A] This authorization expires once PHI is released. This is a one-time release.

_____ *Initials* [16B] This authorization expires six months from the signature date below.

_____ *Initials* [16C] This authorization expires as specified: _____

[17] **TODAY'S DATE:** _____ [18] **SIGNATURE:** _____

[19] **PRINTED NAME:** _____

[20] **RELATIONSHIP:** *Choose One*: ☐ Client(Patient) ☐ Parent ☐ Guardian ☐ Representative ☐ Conservator ☐ Other: _____

[21] **COMPLETE** **ADDRESS** Street Address City State Zip Code _____ **TELEPHONE #** ( ) -

Please return the completed form for processing to the Custodian of Records office, 511 N. Sycamore, Santa Ana, Ca 92701
Phone (714) 834-3536; Fax (714) 835-9312